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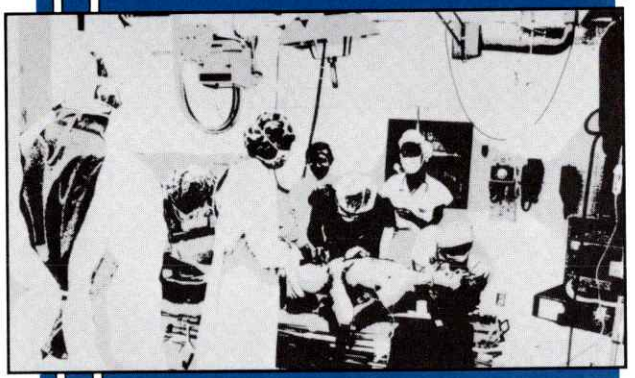

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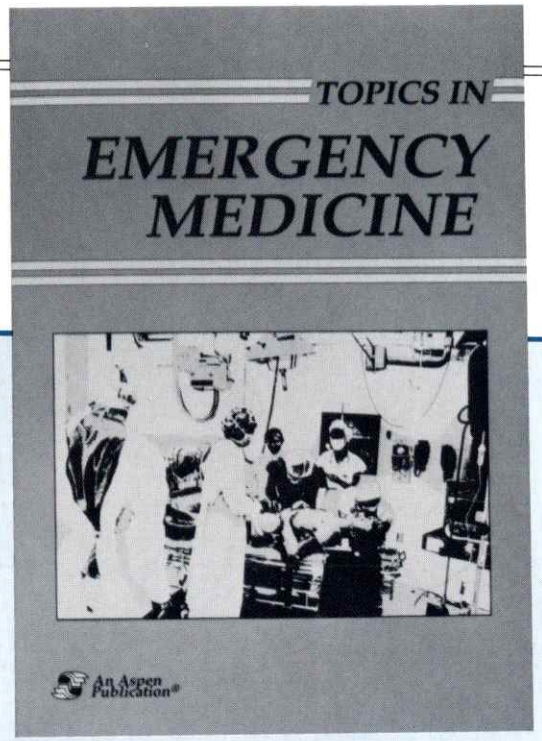

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In a society with a thirst for speed and a high incidence of violence, trauma is now recognized as a disease of epidemic proportions. Today in the U.S., trauma is the third leading cause of death, with the majority of these fatalities resulting from motor vehicle accidents and gunshot wounds. And 10-15% of all trauma deaths are the result of abdominal injuries.

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15:1 Blunt and Penetrating Abdominal Trauma, Part 1

Issue Editor: Anthony S. Morgan, MD, FACS

Assessment of the Injured Abdomen, *Alison Lane-Reticker, MD, FACEP*

Learn which functions should be monitored, what signs might prove fatal, which patients need operative care, and what questions to ask the patient if you get the chance. Review assessment and stabilization of airway, breathing and circulation, and identifying and prioritizing injuries. Also gain special insight into care of the pregnant patient.

Diagnostic Techniques in Blunt and Penetrating Abdominal Trauma, *Judith L. Pepe, MD*

Compare diagnostic modalities designed to aid you in assessing intra-abdominal injuries, including diagnostic peritoneal lavage, ultrasonography (US), computed tomography scanning (CT) and diagnostic laparoscopy, along with the indications, contraindications, advantages and disadvantages of each method. Charts for instant comparison of these assessment modalities and sample US and CT scans of common abdominal injuries are included.

Solid Visceral Injuries: Diaphragm, Liver, Spleen and Kidney, *Anthony S. Morgan, MD, FACS*

Clarify the difference between blunt trauma and penetrating trauma to the diaphragm, the difficulties in assessment, and the need for prompt treatment. Research indicates that improved imaging techniques, and new trends in operative and nonoperative management positively affect patient outcomes.

Hollow Visceral Trauma: Stomach, Duodenum-Pancreas, Intestine, Colon, and Rectum, *Elsa R. Hirvela, MD*

Delayed diagnosis of visceral perforations and major pancreatic trauma still have a significant impact on mortality and morbidity among hollow visceral trauma patients. Increase your awareness of the anatomy, mechanisms of injury, limitations of diagnostic procedures, and common injuries and how they present themselves so you can insure optimal outcomes for your patients.

Management of Penetrating Abdominal Trauma, *Brian R. Plaisier, MD, and Lenworth M. Jacobs, MD, MPH, FACS*

Follow guidelines for systematic evaluation of torso injuries to make sure you don't overlook specific points of damage and to help you restore your patient to a preinjury level of function. View the abdomen and thorax as a combined unit to avoid preoccupation with one body cavity and unnecessary delay in assessment and treatment to the other.

Blunt Retroperitoneal Injuries, *Wendell A. Goins, MD, FACS, and Aurelio Rodriguez, MD, FACS*

Study optimal treatment plans for retroperitoneal hematoma (RPH) resulting from blunt trauma, including careful attention to exposure and vascular control of suspected major vessel injuries, and the rare case of Zone III RPH, which requires surgical exploration when major iliac blood vessel damage is indicated.

Pelvic Ring Injuries, *Andrew R. Burgess, MD*

Evaluate suggested physical and radiologic examinations for pelvic ring injury, and hidden visceral and/or neurovascular injuries that need urgent attention, along with techniques for external and internal fixation treatment that can influence the long-term effects of this skeletal injury on your patient's mobility.

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